EMS SKILLS EVALUATOR WORKSHOP
COURSE ROSTER

WORKSHOP INSTRUCTOR NAME: _____ **DAYTIME PHONE:** _____

(Please print) First M.I. Last

MAILING ADDRESS: _____

Street Address or P.O. Box City State Zip Code

WORKSHOP COMPLETION DATE: _____ **WORKSHOP LOCATION:** _____

I verify that the following persons have successfully completed a workshop addressing methods and techniques of consistent and objective practical skills evaluation using Washington State Department of Health identified forms.

_____ _____

Signature of Workshop Instructor Date

PLEASE TYPE OR PRINT LEGIBLY

NOTE: Individuals must also complete and submit to DOH an EMS Skills Evaluator application with required signatures.

NAME OF PARTICIPANT	EMS REGISTRY NUMBER (# ON DOH CERTIFICATION CARD)	DAYTIME PHONE

Please return completed form to:

DOH, EMS and Trauma System
Education, Training & Regional Support Section
P.O. Box 47853

Olympia, WA 98504-7853

PLEASE TYPE OR PRINT LEGIBLY

NAME OF PARTICIPANT	EMS REGISTRY NUMBER (# ON DOH CERTIFICATION CARD)	DAYTIME PHONE